

Registration District No. **827**

Primary Registration District No. **6089**

Registrar's No. **5**

1. PLACE OF DEATH:

(a) County **SHELBY**  
(b) City or town **CLARENCE Rural**  
(c) Name of hospital or institution: **1 Clary St**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME **MARY C FOSTER**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOW**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **8 - 10 - 1852**  
(Month) (Day) (Year)

8. AGE: Years **88** Months **6** Days **6** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Ohio**  
(City, town, or county) (State or foreign country)

10. Usual occupation **FARMHOUSE Keeper**

11. Industry or business \_\_\_\_\_

12. Name **John Luning**

13. Birthplace **Ohio**  
(City, town, or county) (State or foreign country)

14. Maiden name **Widow**

15. Birthplace **Ohio**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Harlan Foster**

(b) Address **Clarence 720**

17. (a) **Burial** (b) Date thereof **2-18-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Evergreen Cem**

18. (a) Signature of funeral director **Wm J. Hamilton**

(b) Address **Clarence 720**

19. (a) **Feb 22 '41** (b) **Ray Hamilton**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Shelby**  
(c) City or town **Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **16**  
year **1941** hour **1** minute **10** M.

21. I hereby certify that I attended the deceased from **Feb 14**, 19**41**, to **Feb 16**, 19**41**;  
that I last saw her alive on **Feb 14**, 19**41**,  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral apoplexy with left hemiplegia**  
Due to **hypertension**  
Due to \_\_\_\_\_

Other conditions **influenza**  
(Include pregnancy within 3 months of death) **1 week**  
**in Jan 1941**

Major findings: **no operation**  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
**2 da**  
**10 yrs**  
**1 week**  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **951**

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury **SMO**

23. Signature **D. L. Harlan** (M. D. or other) **SMO**  
Address **Clarence 720** Date signed **2/24/41**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

02  
06

0-17-37  
PI X2315

**MAR 19 1941 827**

RECEIVED

District Health Officer No. 10

District File Number 3-41-546

Date Filed MAR 10 1941

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Henry T. Bachelier*

Licensed Embalmer No.

*3835-9*

P. O. Address

*Shelburne, Me.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 827

Primary Registration District No. 6089

1. PLACE OF DEATH

(a) County Shelby  
(b) City or town Clay T.P.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Mary C. Foster  
3. (b) If veteran. name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased 8-10-1852  
(Month) (Day) (Year)

8. AGE: Years 88 Months 6 Days 6 If less than \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 2-22-41 (b) Ray Hamilton  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 16  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide; or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature D.L. Harlan (M. D. or other) \_\_\_\_\_

Address Clarence \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1941

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**